Beth Israel Deaconess
CARE ORGANIZATION

Affiliated with
Beth Israel Deaconess Medical Center
HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

September 11, 2015

Mr. David Seltz
Executive Director
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Dear Executive Director Seltz,

On behalf of Beth Israel Deaconess Care Organization (BIDCO), enclosed please find written testimony for Exhibits B and C (Questions for Written Testimony) in response to the Health Policy Commission letter to BIDCO dated August 6, 2015.

I hope that the enclosed testimony is helpful to the Commission and to the Office of the Attorney General; we would be happy to provide any additional information that may be helpful to you.

I am legally authorized and empowered to represent Beth Israel Deaconess Care Organization for the purposes of this testimony, and provide the testimony herein under the pains and penalties of perjury.

Very truly yours,

Jeffrey Hulburt
Interim President and CEO

CC: Karen Tseng, Chief, Health Care Division, Office of the Attorney General
CC: Áron Boros, Executive Director, Center for Health Information and Analysis

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Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Monday, October 5, 2015, 9:00 AM
Tuesday, October 6, 2015, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on both days. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email at Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the questions and exhibits as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please complete your responses in the provided **Microsoft Word** template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

We encourage you to refer to and build upon your organization's 2013 or 2014 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. If a question is not applicable to your organization, please indicate so in your response.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any other questions regarding this process or regarding the following questions, please contact Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 224) sets a health care cost growth benchmark for the Commonwealth based on the long-term growth in the state's economy. The benchmark for growth in CY2013 and CY2014 is 3.6%.
    a. What trends has your organization experienced in revenue, utilization, and operating expenses in CY2014 and year-to-date CY2015? Please comment on the factors driving these trends.

Beth Israel Deaconess Care Organization (BIDCO) is currently in its third year of operation. Prior to 2013, BIDCO's predecessor organization, Beth Israel Deaconess Physician Organization, represented physician groups affiliated with the Beth Israel Deaconess Medical Center. Today, BIDCO represents nearly 2,400 physicians and 7 hospitals in eastern Massachusetts who share risk and build care management systems together. BIDCO has engaged in commercial global budget risk contracts for five years and the Centers for Medicare and Medicaid Service's (CMS) Pioneer Accountable Care Organization (ACO) global budget risk program for four years.

Similar to 2014, BIDCO's participation in risk contracts has, by contractual design, stabilized revenue trends in 2015. For the one plan for which utilization information is available, BIDCO experienced lower utilization trends than the plan's network for inpatient admissions from 2013 to 2014. In terms of commercial utilization, adult medical/surgical admissions per 1,000 decreased 7% from 2013 to 2014, and decreased 5% from 2014 to 2015, seasonally adjusted. In terms of operating budget, year-over-year changes are a result of changes to the composition of the network, the introduction of new medical management programs and IT infrastructure, and the ability to incorporate appropriate analytic applications into BIDCO's operations.

The factors driving the above-described trends include the following: In 2014, BIDCO invested in enhancements to quality management systems, financial management systems, and technology, all of which supported the organization's quality and cost goals. In 2015, BIDCO only added modestly to that base infrastructure, and was able to achieve even greater gains in these areas. Because BIDCO's covered lives increased from 2014 to 2015, the operating budget actually decreased on a PMPM basis for BIDCO's member organizations. BIDCO continues to take on more administrative functions, such as high risk care management, when managing risk patients in cost and quality without a commensurate increase in funding or a commensurate decrease in premiums to employers or subscribers for having transferred the function to BIDCO.

    b. What actions has your organization undertaken since January 1, 2014 to ensure the Commonwealth will meet the benchmark, and what have been the results of these actions?

BIDCO continues to focus on helping providers manage total cost of medical care while maintaining and improving quality performance. The integration of hospitals and physicians as co-managers of patient care has fostered collaboration and lessened fragmentation of care. Last year, BIDCO reported that the organization was developing a financial risk sharing model for its member hospitals and physicians. BIDCO continued to refine that work, which included input from its member

physicians and hospitals, and implemented the model in 2015. Insufficient time has lapsed in order to measure the financial effect of these changes; however, some of the positive effects of operational changes that accompanied the model adjustment are evident. One operational improvement of the new financial model is the creation of "Risk Units." Risk Units consist of a hospital and its affiliated primary care physicians who together share financial risk to meet BIDCO's goals to improve quality and manage total medical expenses. BIDCO coordinates monthly Risk Unit meetings with physician and hospital leaders to review reports that track the Risk Unit's progress on specific goals. The meetings are also instrumental in identifying operational and clinical issues and implementing innovation solutions.

BIDCO is also continuing to expand its HouseCalls Medicine Program, a home-visit program for patients in certain high-risk categories, including those at high risk for inpatient admission or who have multiple chronic conditions. BIDCO recently transitioned the HouseCalls Medicine Program from a vended service to an in-house program managed by BIDCO employees and staffed by nurse practitioners experienced in geriatrics and home visits, with the dual objective to achieve a greater return on investment and increase satisfaction from patients and providers. The results to date are tracking positively for newly enrolled patients, with a 43.2% decrease in emergency department visits and a 12% decrease in admissions compared to the previous 12 months. However, since the transition to an in-house program is fairly recent and these results are based on limited data, BIDCO plans to continue to monitor the experience across a longer time period.

c. Please describe specific actions your organization plans to undertake between now and October 1, 2016 to ensure the Commonwealth will meet the benchmark, including e.g., increased adoption to alternative payment methods (including specifically bundled/episodic payments), participation in CMS Medicare Shared Savings, Pioneer or Next Gen programs?

BIDCO is always assessing opportunities to shift more business into alternative payment models that are structured in ways that balance risk between payers and providers. In fact, BIDCO is a member of the Healthcare Transformation Task Force, whose members are committed to putting 75% of their respective business in value-based payment arrangements by January 2020, and serves on the Task Force's High-Cost Patient Workgroup, ACO Workgroup, and Bundled Payment Workgroup. As a Pioneer ACO, BIDCO has gained considerable experience with managing alternative payment contracts, which it plans to continue to expand in the upcoming year. BIDCO includes primary care providers, specialists and community and tertiary hospitals. For that reason, bundled payments are one option for managing total cost of care. Payers often have system limitations that prevent them from being able to administer a bundled payment within their claims and financial reporting systems, but BIDCO is well-poised to promote bundled and other alternative payment methods. Through its risk sharing methdology, BIDCO is in an ideal position to set up the program in 2016 in a way that creates both appropriate incentives for targeted providers, as well an operational process for administering such a program. Additionally, BIDCO plans on continuing to participate in an alternative payment model with CMS for 2016, either in the Pioneer ACO model or in the Next Generation model that is beginning in January 2016. As was recently reported in CMS's Performance Year 3 Report, BIDCO has experienced success as a Pioneer ACO in each of the three years that have settled, and projected results for 2015 remain strong.

d. What systematic or policy changes would encourage or enable your organization to operate more efficiently without reducing quality?

BIDCO continues to advocate for three policy changes that would enable the organization to achieve greater efficencies while improving quality. First, payers should be required to offer PPO and self-insured, risk-based alternative payment arrangements. Payers are moving toward creating alternative payment models for PPO patients, although administrative issues, such as methodologies for charging surpluses to employer accounts, make this more difficult for payers to implement.

Second, there should be a stronger regulatory approach to rein in wide price disparities in the Massachusetts health care market, particularly in the eastern communities. Without regulatory intervention, the wide price disparities that have existed for the past 20 years, and have been documented by the Office of the Attorney General and others, will likely continue due to the fact that the new health care cost growth benchmark imposed by Chapter 224 is having the unintended effect of freezing the current disparities in place without meaningfully addressing them. BIDCO also encourages coordination and collaboration between the Health Policy Commission (HPC) and other state agencies with responsibilities related to Chapter 224, such as the work involved in RPO and RBPO registration, as they work with the regulated community to limit duplication of effort and to truly achieve the goal of the law—to improve the quality of health care and reduce costs.

Third, improvements can be made in the support provided by payers to providers under risk arrangements. First, quality measurement and patient attribution methodologies across public and private payers should be aligned in order to establish uniformity and parity, which would enable providers to apply improvement efforts in a more focused manner and achieve greater success. BIDCO continues to request more actionable and timely data from the health plans, but the delay in receiving financial performance and trend data under BIDCO's risk contracts significantly challenges the organization's ability to adequately determine and evaluate current payer expense trends. From a risk-bearing provider organization perspective, it would be helpful to receive real-time data on hospital admissions or emergency department utilization to manage patient care, as well as more timely comparative quality information. Finally, BIDCO regularly receives comparative quality information on claims-based process measures within risk contracts from only one payer, and an overall performance comparison at the end of the calendar year from all payers with quality components, which is not as helpful in setting and evaluating population health management goals and initiatives.

BIDCO applauds the work of all state agencies charged with implementing Chapter 224 and encourages the continued delegation of administrative functions from health plans to provider organizations that allow provider organizations to manage the cost of care and improve quality. BIDCO recommends covering the costs of those functions with the premium collected by payers. Provider organizations are closer to the provision of service to patients and are well-positioned to achieve success in managing costs, increasing patient satisfaction with the health care system, and improving quality.

2. What are the barriers to your organization's increased adoption of alternative payment methods and how should such barriers be addressed?

While BIDCO continues to seek expansion in the number of alternative payment arrangements it participates in, there are still barriers, both internal and external to the organization, to increasing the adoption of these arrangements that BIDCO recommends addressing.

The internal barriers result from the wide variety of alternative payment methodologies that have developed in the market place. For example, while most arrangements have some quality measurement as a requirement, each payer chooses the measures and the criteria for performance on which the arrangement will pay out. This creates a significant burden for a provider to create multiple programs to support initiatives of improvement. This barrier could be addressed by standardizing the metrics that are used to assess quality of care. Another internal barrier relates to the infrastructure needed to support alternative payment arrangements. Providers do not yet have a large enough portion of business in alternative payment arrangements to gain efficiencies in infrastructure support and will continue to have difficulty supporting significant financial investments over a short period of time. This barrier could be addressed by building an appropriate level of infrastructure support into alternative payment contracts Limitations on infrastructure costs going forward could potentially pose barriers to adopting global payments.

The external barriers result from several aspects of payers' commercial business related to self-insured accounts and the difficulties in incorporating alternative payment model components, such as charging the payment of surplus, to this type of account. Many self-insured accounts have selected this payment methodology in order to pay for care based on the actual experience of their employees and to own the risk associated with their employees. Since alternative payment methodologies create surplus payments related to the reduction of actual experience, there can be a conflict between the goals of the self-insured accounts and the operational structures relating to rewarding providers for improved performance.

The second external barrier stems from the variety and multitude of quality measures which are adopted by the payers as a component of the alternative payment program. As stated earlier, when each payer has a different set of measures, or the same measure that is calculated differently, providers and the ACOs that they join cannot focus their resources in an efficient and effective manner. In the end, standardizing quality measures would assist in the advancement of improvements to care. Providers could focus on a consistent set of quality metrics, thereby reducing the infrastructure needed to support the arrangements.

3. In its prior Cost Trends Reports and Cost Trends Hearings, the Commission has identified four key opportunities for more efficient and effective care delivery: 1) spending on post-acute care; 2) reducing avoidable 30-day readmissions; 3) reducing avoidable emergency department (ED) use; and 4) providing focused care for high-risk/high-cost patients.
    a. Please describe your organization's efforts during the past 12 months to address each of these four areas, attaching any analyses your organization has conducted on such efforts.

BIDCO has implemented numerous programs in each of these four areas to ensure that providers in the BIDCO network deliver the most efficient and effective care.

Spending on Post-acute Care

To address spending on post-acute care, BIDCO developed three new initiatives:

1. BIDCO developed a Skilled Nursing Facility (SNF) Quality Collaborative, which identifies SNFs that reliably provide superior care, meet specific quality measures, and have developed a closer working relationship with both referring hospitals and BIDCO staff.
2. BIDCO manages the lengths of stays at SNFs throughout the BIDCO network, including those SNFs which are part of the Quality Collaborative, through the hiring and deployment of a SNF Liaison Nurse.
3. BIDCO created a "Patient Mobilization Pilot" program at BIDMC's inpatient acute care unit. The pilot creates an interdisciplinary group, including nurses, physical therapists and occupational therapists, who focus on providing assistance for patients to become more mobile and functional so that they can be discharged directly to their homes.

Reducing Avoidable 30-day Readmissions

BIDCO has a number of initiatives that reduce avoidable hospital readmissions, in addition to the SNF Quality Collaborative and the Patient Mobilization Pilot programs described above. For example, BIDCO operates a HouseCalls Medicine Program where Nurse Practitioners, in coordination with a patient's primary care provider (PCP), provide in-home medical care to Medicare Pioneer ACO patients who are identified as being at high-risk for hospitalization or readmission using a risk stratification algorithm. Using a PCP collaborative practice model, patients who have multiple chronic conditions with associated functional or cognitive issues or psychosocial complications are referred by the PCP and receive a comprehensive evaluation from the HouseCalls Medicine Program Nurse Practitioner in the comfort of their home. The HouseCalls Medicine Program Nurse Practitioner then works collaboratively with the PCP to manage the patient's care.

BIDCO's Three-day Skilled Nursing Facility (SNF) Rule Waiver initiative also reduces avoidable 30-day readmissions by allowing patients selected in accordance with the CMS criteria to be directly admitted to pre-approved SNFs, bypassing the three-day hospital stay otherwise required by Medicare. The Three-day SNF Rule Waiver initiative, which BIDCO applied for and received in 2014, provides medical services similar to those offered at a hospital, including rehabilitation services, ultimately reducing the time a patient spends in a hospital and away from home while improving the patient's experience. The initiative also allows for better coordination of care, including timely outreach for patient follow-up and patient referrals to appropriate community resources, targeted education, and support in the home upon discharge. Through this initiative, BIDCO works with SNFs who can reliably monitor program progress and care outcomes.

BIDCO has also developed Emergency Department guidelines in collaboration with one of its member hospitals, BIDMC, which directly address the shared objective to reduce avoidable 30-day readmissions. The new guidelines improve collaboration between outpatient services -- such as urgent care, primary care, and home infusion programs -- and the Emergency Department in ways that provide

patients with timely and appropriate follow-up care, thereby improving their medical condition and reducing the likelihood they will be admitted to a hospital. More specifically, Emergency Department guidelines focused on cellulitis and falls are designed to mitigate admissions and ensure that a patient is directed to the most-appropriate care setting. These guidelines are planned to eventually be rolled out to other BIDCO-affiliated hospitals.

Finally, BIDCO's Advanced Illness/Palliative Care Disease Management Initiative helps reduce readmissions at the end of life by providing PCPs with data to prioritize advanced care planning conversations with identified patients. The overall goal of the initiative is to improve the delivery of palliative care by identifying patients with palliative care needs and addressing those needs earlier in the illness trajectory and in a more effective manner.

Reduce Avoidable Emergency Department Use

Several of the aforementioned initiatives also reduce avoidable Emergency Department use, including the HouseCalls Medicine Program and the Three-day SNF Rule Waiver initiative. In addition, as part of BIDCO's efforts to ensure that patients receive care in the most clinically appropriate settings, BIDCO educates BIDCO-affiliated physicians about services available in community settings. Recent examples include an urgent care facility in Chestnut Hill and an after-hours weekend clinic at a primary care practice in Needham.

Providing Focused Care for High-Risk/High-Cost Patients

BIDCO's Care Management and HouseCalls Medicine programs are excellent examples of providing focused care for high-risk, high-cost patients. In the Care Management program, Community Nurse Care Managers work with BIDCO PCPs and their acute and chronically ill patients to provide individualized care management to those who are at high risk for hospitalization and/or readmission but are not in BIDCO's HouseCalls Medicine program. In the HouseCalls Medicine Program, BIDCO uses the same risk-stratification methodology for care management of chronically ill patients who have the highest risk stratification scores and higher total medical expenses. The HouseCalls Medicine Program also provides patients access to a Nurse Practitioner who collaborates with a PCP.

b. Please describe your organization's specific plans over the next 12 months to address each of these four areas.

In the next 12 months BIDCO plans to partner with community-based social services, expand the reach of the HouseCalls Medicine and Patient Mobilization programs, and improve the management of patients with chronic obstructive pulmonary disease and chronic renal failure, especially those on dialysis, through disease management initiatives. BIDCO plans to implement the ED guidelines developed in association with BIDMC at all BIDCO-affiliated hospitals in 2015. Finally, BIDCO plans to further support and encourage providers to engage in and document goals-of-care and advanced directive conversations with patients by providing ongoing educational outreach to PCPs, identifying patients by practice at high mortality risk, and partnering with community-based palliative care services. BIDCO also plans to continue to gather results and evaluate its programs at regular intervals, making needed improvements to the existing structure of programs as necessary.

4. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Center for Health Information and Analysis in 2012, 2013, and 2015; and by the Health Policy Commission in 2014, prices paid to different Massachusetts providers for the same services vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value. Reports by the Office of the Attorney General have also identified significant variation in global budgets.
    a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?

Global budgets and provider pricing currently vary due to a variety of reasons, some of which BIDCO supports. For example, providers who are priced equitably within their geographic market but who care for a sicker or more complex population of patients incur higher overhead costs in carrying out functions that health plans normally pay for at a premium cost. However, global budgets and provider pricing also continue to vary due to the market dominance of a few provider systems. BIDCO applauds the Commision's and Attorney General's transparent and important reporting on the disparities in health care pricing among like-institutions in Massachusetts. Health plans, providers, and regulatory agencies need to continue to move toward moderating disparities. As a system, BIDCO continues to focus on fair and competive pricing and controlling health care costs while promoting and implementing improved quality performance, as an ACO.

    b. Please describe your view of the impact of Massachusetts' price variation on the overall cost of care, as well as on the financial health and sustainability of community and lower-cost providers.

The wide price variations that have existed in Massachusetts for the past 20 years are still present. The health care cost growth benchmark, while an important component of an overall cost-control system, has the unintended consequence of maintaining a self-perpetuating status quo in the health care market, with both overly-paid providers and underpaid providers. Those at the lower end of the price variation continuum have a reduced ability to invest in systems of care that help them to better manage cost and improve quality. Direct clinical care equipment, updates to facilities, initial purchases or upgrades of IT systems, ancillary staff such as NPs, RNs, and LICSWs, and investment in other infrastructure are all examples of expenditures that would assist community and lower-cost providers in improving care and potentially attracting more patient volume to their sites of care. However, these improvements and updates are not always financially attainable due to the lower-cost providers' frozen position in the price variation continuum.

5. The Commission has identified that spending for patients with comorbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health condition. As reported in the July 2014 Cost Trends Report Supplement, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
    a. Please describe ways that your organization has collaborated with other providers over the past 12 months 1) to integrate physical and behavioral health care services and

provide care across a continuum to these patients and 2) to avoid unnecessary utilization of emergency room departments and inpatient care.

BIDCO has taken steps over the past year to integrate physical and behavioral health care services into its care management program. For example, BIDCO has a robust Care Management program, which pairs Community Nurse Care Managers with Primary Care Providers to manage higher risk, complex care patients. This progam serves these high need patients with the express goal of tending to their social and physical needs while also making referrals to behavioral health services when necessary to ensure that patients can stay in their home and out of the emergency department. To achieve this goal, BIDCO Community Nurse Care Managers leverage community resources, such as Visting Nurse Association services, elder care services, and behavioral health services. For patients in BIDCO's Pioneer ACO program, BIDCO has a HouseCalls Medicine program where Nurse Practitioners visit high-risk patients in their homes, providing clinicians with the opportunity to see other social and environmental factors affecting a patient's health. The HouseCalls Medicine program Nurse Practitioners work collaboratively with the patient's PCP and a Nurse Care Manager, if one is assigned, to manage and provide appropriate care to the patients in their home and prevent unnecessary hospitalizations. The program's Nurse Practitioners consider a broad array of health factors of their patients when conducting visits, including behavioral health status. BIDCO also employs a social worker who works closely with high-need patients to ensure that they are linked to necessary services, including access to behavioral health resources, while avoiding unnecessary utilization of emergency departments. The BIDCO Social Worker provides these services in coordination with BIDCO's Care Management program and patients' primary care teams.

BIDCO also initiated a pilot program earlier this year with Riverside Community Care (Riverside), an organization that delivers locally-based, integrated behavioral healthcare and human services, to address behavioral health care needs of BIDCO primary care practice patients. The shared objective is to integrate primary and behavioral health care to improve quality and reduce the cost of care delivery for patients with behavioral health needs. This project is modeled off of the Collaborative Care Model of primary and behavioral health care integration, which is clinically known to improve quality and reduce health care costs. Through the pilot with BIDCO, Riverside retained a Behavioral Health Integration (BHI) Manager who was tasked with working directly with two BIDCO physician practices. The BHI Manager links patients to the full array of community-based behavioral health supports, including psychiatric emergency and ugent care service providers. The BHI Manager also supervises the behavioral health clinicians who are hired to work within each primary care practice. The behavioral health clinicians provide short-term and/or intermittent interventions and supports, including "just in time" assessments, formal and informal consultation to the physician and the patient, short-term cognitive-behaviorally focused therapy, and when necessary, referral for longer term behavioral health services with coordination and follow-up. These co-located clinicians ensure consistency in behavioral health service delivery within the primary care practices due to their proximity to the PCPs. As a result, the structure facilitates effective and timely behavioral health care services to BIDCO patients.

b. Please describe your specific plans for the next 12 months to improve integration of physical and behavioral health care services to provide care across a continuum to these

patients and to avoid unnecessary utilization of emergency room departments and inpatient care.

BIDCO plans to continue its programs that improve care across a continuum and avoid unnecessary utilization of emergency department and inpatient care, including integration of behavioral and physical health. BIDCO plans to continue the evaluation of these programs and to explore ways to implement improvements. The pilot program underway with Riverside Community Care is anticipated to continue through the end of 2015. In 2016, BIDCO anticipates expanding the pilot and making programmatic adjustments based on the pilot's experience to allow for greater coverage and efficiency within the practices.

Two significant impediments to continuation or further expansion of the pilot are: (1) the continuation of low payments to providers from payers for behavioral health services, and (2) the continuation and expansion of payers shifting financial responsibility of behavioral health services to carve-out behavioral health insurers, which further erodes the integration of medical and behavioral health services for patients.

6. The Commission has identified the need for care delivery reforms that efficiently deliver coordinated, patient-centered, high-quality care, including in models such as the Patient Centered Medical Home (PCMH) and Accountable Care Organizations (ACOs). What specific capabilities has your organization developed or does your organization plan to develop to successfully implement these models?

BIDCO's central mission includes delivering coordinated, patient-centered, high-quality care to its patients, through its network. All providers who join the BIDCO network participate in its Pioneer ACO contract, and are part of the BIDCO ACO. The Pioneer ACO model includes a global budget, encourages care coordination and improved quality, and rewards ACOs that beat the budget with a portion of the savings or, alternatively, holds ACOs accountable for a portion of losses. BIDCO's focus on the promotion of quality improvement, care management and other services has resulted in three consecutive years of savings as a Pioneer ACO, totaling nearly $50 million in savings. BIDCO also has global risk contracts with several commercial plans, including Harvard Pilgrim Health Care and Tufts Health Plan, which similarly focus on improved quality and care coordination.

Additionally, BIDCO provides services to members to help them meet total medical expense and quality targets. For example, BIDCO regularly provides detailed financial performance reports, including routine utilization and cost reporting. BIDCO provides members with training and ready access to the necessary population management tools to better manage their patient care and costs. BIDCO also provides its membership with analyses of areas of concern for a hospital, physician group or an individual physician. For example, such reports can include identifying areas of higher than average radiology utilization, inpatient readmissions or variation in treatment of specific outpatient conditions. These tailored reports allow the practices to understand cost and utilization drivers unique to their practice or service area.

BIDCO makes strong performance on quality measures a high priority, and therefore allocates resources which enable hospitals and physicians to monitor and improve on their performance. BIDCO

provides members with the tools to improve quality scores in a variety of ways. For example, BIDCO educates practices on quality measures in payer contracts, assists practices in implementing and using systems to improve patient care and outcomes, and provides practices the clinical data needed to satisfy contract requirements. Additionally, BIDCO tracks quality measure performance for primary care practices, creates practice-specific improvement plans, and assists PCPs and their office staffs in work flow optimization in order to achieve quality incentives.

BIDCO also provides a menu of medical management programs to better coordinate patient care. For example, BIDCO provides PCPs with information that identifies their highest risk patients, and these patients are followed by the BIDCO HouseCalls Medicine Program. In this program, Nurse Practitioners, in coordination with a patient's PCP, provide in-home medical care to Pioneer ACO patients who are identified as being at the highest risk for hospitalization or readmission using a risk stratification algorithm. Using a PCP collaborative practice model, patients who have multiple chronic conditions with associated functional or cognitive issues or psychosocial complications receive a comprehensive evaluation in the comfort of their home.

In BIDCO's Care Management program, Community Nurse Care Managers work with BIDCO PCPs and their acute and chronically ill patients to provide individualized care management to those who are at high risk for hospitalization and/or readmission but are not in the BIDCO's HouseCalls Medicine program.

BIDCO's Three-day SNF Rule Waiver initiative also contributes to the shared objected to better coordinate care by allowing carefully selected patients to be directly admitted to pre-approved SNFs, bypassing Medicare's required three-day hospital stay. The initiative provides medical services similar to those offered at a hospital, including rehabilitation services, ultimately reducing the time a patient spends away from home while improving the patient's experience. The initiative also allows for better coordination of care, including timely outreach for patient follow-up and patient referrals to appropriate community resources, targeted education, and support in the home upon discharge. Through this initiative, BIDCO works with preferred SNFs who can reliably monitor program progress and care outcomes.

BIDCO has also established a Pharmacy Management Program designed to optimize medication efficiency, efficacy, and safety while ensuring high-quality patient care. The program aligns with BIDCO's global payment contracts with several major health insurance carriers. A Clinical Pharmacist is assigned to a physician group for outreach, consultation, and utilization review. Pharmacists are assigned to one of the following four domains of care to develop interdisciplinary pilots and protocols: complex care management, medication adherence assistance, quality metrics review, and disease management program support.

Additionally, BIDCO launched a Patient Mobilization Pilot in which BIDCO partnered with Beth Israel Deaconess Medical Center (BIDMC) to help patients return home more quickly and safely after their inpatient admission. The pilot creates an interdisciplinary group, including nurses, physical

therapists and occupational therapists, who focus on getting patients moving to a functional state whereby they can be discharged directly home. This effort promotes collaboration among staff to improve the functional abilities of patients during necessary hospitalizations and to increase the likelihood that hospitalized patients will be able to further their recovery in the comfort of their homes, instead of a long stay at a skilled nursing facility. This initiative is planned to be rolled out to other BIDCO-affiliated hospitals by the end of the calendar year.

Finally, BIDCO's focus on disease management complements other initiatives in population health management. Specifically, BIDCO is implementing disease management efforts in the following areas: palliative care, chronic kidney disease, and chronic obstructive pulmonary disease. These initiatives are designed to be managed within BIDCO's primary care practices, rather than centrally at BIDCO. BIDCO has developed tools to identify appropriate patient candidates, selected education and training materials for physicians, and provided the IT tools needed to measure the project's success.

7. Since 2013, Beth Israel Deaconess Care Organization (BIDCO) has completed a number of material changes, including affiliating with multiple hospitals and provider groups such as Beth Israel Deaconess-Plymouth (formerly Jordan Hospital), PMG Physician Associates, Cambridge Health Alliance, Anna Jacques Hospital, Whittier IPA, and Lawrence General Hospital. Please provide information, as described in more detail below, about these recent material changes and attach analytic support for your responses where available.
    a. How have costs (e.g., prices and total medical expenses), referral patterns, quality, and access to care changed after these material changes?

Costs

Since last reported for the 2014 Health Care Cost Trends Hearing, BIDCO continues to reduce growth in total medical expense as evidenced by its performance in the Pioneer ACO Model. In 2014, the third and most recently reported performance year of the Pioneer ACO Model, BIDCO generated $16.3 million in savings. $9.8 million of the savings will go to BIDCO providers under the shared savings agreement with the Centers for Medicare and Medicaid Services (CMS), while $6.5 million will remain with the Medicare Trust Fund.

Referral patterns

A founding priciple of BIDCO is the expectation that BIDCO providers refer to other in-network providers and facilities when clinically appropriate and to the extent that it is allowable by the payer to promote improved care coordination and management (Medicare as a payer has broader beneficiary provider choice). Inherent in that expectation is that BIDCO providers use local community hospitals and limit referrals to BIDCO's academic medical center member, Beth Israel Deaconness Medical Center (BIDMC), to the highest acuity cases. BIDCO has experienced significant shifts in utilization as the community network has grown, and providers are incentivized to keep care local and in-network. For example, when Cambridge Health Alliance joined BIDCO in January 2014, they experienced a 9% increase in Blue Cross Blue Shield commercial adult medical/surgical admissions to BIDMC along with a 35% decrease in admissions to Partners HealthCare facilities.

BIDCO continues to seek ways to retain more of its patients' care within the BIDCO network, as appropriate, to maximize the provision of high quality and clinically integrated care. The current tools that insurers use to support these efforts have not proven sufficiently effective, and BIDCO welcomes additional collaboration from health plans and employers to align patient incentives with its own – particularly in light of the growth of PPO enrollment.

Quality

All of BIDCO's provider organizations participate in BIDCO's quality program which consists of four elements: (1) submission of clinical data that is used to fortify claims data, (2) education on the quality measures and sharing of best practices, (3) for ambulatory practices, examination of practice workflow conducted by staff who work directly with provider offices and who encourage practice outreach efforts to patients, and (4) coordination between BIDCO and its hospital members on improvements to hospital quality measure performance in BIDCO risk contracts.

Access to care

As the BIDCO network expands, so too does the number of covered lives in the organization's risk contracts. This growth creates a scale that makes it possible for members to align with business models that are supportive of the goals of risk-based contracting and value-based health care, which are focused less on volume and more on health of the population of patient panels. For example, physician compensation models are moving away from paying for volume to paying for measures of population health and wellness, including measures of access to care and patient satisfaction. This has resulted in primary care practices offering extended and weekend hours and in the opening of new urgent care clinics to diversify health care settings that are appropriate to the localities and communities served by these providers.

b. In pursuing these affiliations, BIDCO indicated that "care management programs and best practices will be integrated across the BIDCO network." What progress has been made on integrating care management programs and best practices across the BIDCO network and with BIDH-Plymouth, PMG Physician Associates, Anna Jacques Hospital, Whittier IPA, Cambridge Health Alliance, Cambridge Health Alliance Physician Organization, and Lawrence General Hospital, in particular? What has been the impact of this integration?

BIDCO engages in a thorough "onboarding" process with all new hospital and physician members, including those mentioned above, that educates members on BIDCO programs and expectations. Physicians and hospitals are provided a detailed understanding of BIDCO's disease management programs, and are also taught how to leverage BIDCO's high-risk patient methodology to identify patients who would benefit from more high-touch programs like the Care Management program, Three-day Skilled Nursing Facility Rule Waiver initiative, and HouseCalls Medicine program.

All new hospital and physician members are required to attend and actively participate in "Pod" meetings and "Risk Unit" meetings. Pods are groupings of primary care physicians who are brought together based on geography, employment and panel size. Each Pod designates a leader, and these leaders are required to share best practices and meet monthly with the BIDCO management team. A

Risk Unit consists of a hospital and its affiliated Pod, and together they share financial risk and work toward meeting BIDCO's goals to improve quality and manage total medical expenses. Starting in 2015, designated participants from a Pod and its affiliated hospital convene monthly to solve issues and identify strategies to improve BIDCO's performance on total medical expense and quality initiatives. This proactive structure ensures that the organization's physician and hospital members play a key role in BIDCO's programs and overall efforts to reduce total medical expenditures. For example, Risk Units are currently engaging in initiatives to reduce variation in rates of utilization of certain outpatient procedures. Additionally, BIDCO has established working committees, two of which are to play a key role in assessing the current state and planning the future structure of care management programs. These committees plan to assess results to date and review what is being done regionally and nationally in order to make improvements.

BIDCO plans to continue to assess the effectiveness of these newly formed groups and structures as its physician members and hospitals become fully on-boarded.

Other key vehicles for BIDCO to promote integration of its programs include its governance, board and committee structure. Key decisions and program initiatives, monitoring, and adjustments are all raised and fully vetted at regular board and committee meetings.

c. For many of its affiliations, BIDCO indicated it planned to integrate the clinical care data of the affiliating entity into its data warehouse, "where the information will be utilized to improve patient care quality and efficiency, and where the [affiliated entity's providers] will also receive reports and analytics to help meet these goals." BIDCO also stated that, "shared clinical information through EHRs promotes better management of patient health, both in terms of cost and quality of care provided." What progress has been made on these initiatives? Specifically, please provide an update as to integration and utilization of clinical care data into BIDCO's system from BIDH-Plymouth, PMG Physician Associations, Anna Jacques Hospital, Whittier IPA, and Cambridge Health Alliance, and any measureable impact on the cost and quality of care.

BIDCO has made significant progress in its clinical data integration program, which is comprised of BIDCO's submission of EHR clinical data from provider practices to a central BIDCO clinical data repository. BIDCO's overall approach to improving patient care and quality is driven by real-time EHR clinical encounter data. Historically, claims data drives patient quality improvement and efficiency programs. The biggest challenge BIDCO faces with claims data is the time lag -- receiving claims data from payers can take 60 - 90 days, while loading that same data into BIDCO's analytics data warehouse can take another 30 days. Capturing and analyzing clinical encounter data, which is captured daily in BIDCO's EHR systems and then merged with existing and future claims data, eliminates this issue of time lag and achieves the objective of obtaining a focused and current picture of patient care experience. By having the most current information from the patient record, BIDCO and its member providers can rapidly adapt to changing trends at the physician and patient level.

Working directly with caregivers and practice staff, BIDCO also employs EHR Optimization Specialists who focus on accuracy, efficiency and effectiveness of clinical data capture. The goal is to

target rapid improvement at the caregiver and practice level. This approach allows BIDCO to use real-time patient clinical data to alter a practice's workflow, thereby improving patient care.

It is important to note that not all BIDCO members use the same EHR clinical documentation system. In fact, there are over 40 different EHR clinical documentation systems within the BIDCO network. The data validation and normalization challenges are significantly more complex than a network made up of a single or small number of clinical documentation systems. As of today, BIDCO captures approximately 70% of its PCPs' patient data. BIDH-Plymouth, PMG Physician Associations, Anna Jacques Hospital, Whittier IPA, and Cambridge Health Alliance are in various stages of clinical data implementation and validation process and have made continued progress. BIDCO anticipates that all groups will be operational in their submission of clinical data in 2015.

Exhibit C: Instructions and AGO Questions for Written Testimony

Please note that these pre-filed testimony questions are for providers. To the extent that a provider system submitting pre-filed testimony responses is affiliated with a hospital also submitting pre-filed testimony responses, each entity may reference the other's response as appropriate.

1. Please provide the following statistics related to consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b), including but not limited to a summary table (using the template below) showing for each quarter from January 2014 to the second quarter of 2015 the volume of inquiries by method of inquiry (e.g., in-person/phone, website), the number of consumer inquiries resolved (e.g., an estimate was provided), and the types of services (e.g., MRI of knee) to which consumer inquiries pertained. Please explain why any consumer inquiries pursuant to G.L. ch. 111, § 228(a)-(b) were unable to be resolved.

		Number of Inquiries via Telephone/In Person	Number of Inquiries via Website	Number of Inquiries Resolved	Types of Services to which Inquiries Pertained (List)
CY2014	Q1				
	Q2				
	Q3				
	Q4				
CY2015	Q1				
	Q2				

BIDCO is not a direct provider of medical care, and therefore does not share prices for services with patients.

2. Please submit a summary table showing for each year 2011 to 2014 your total revenue under pay for performance arrangements, risk contracts, and other fee for service arrangements according to the format and parameters provided and attached as **AGO Provider Exhibit 1** with all applicable fields completed. To the extent you are unable to provide complete answers for any category of revenue, please explain the reasons why. Include in your response any portion of your physicians for whom you were not able to report a category (or categories) of revenue.

Please see attachment AGO Provider Exhibit 1. Alternative payment contracts contain multiple components which create value for BIDCO; therefore, the response to this exhibit is best represented by the total value of our contracts and for this reason, the data is presented in aggregate form. Please also note that BIDCO did not include data from 2010, 2011 and 2012 due to the nature of the organization's fundamental change at the end of 2012.

3. Please explain and submit supporting documents that describe (a) the process by which your physicians make and receive patient referrals to/from providers within your provider organization and outside of your provider organization; (b) how you use your electronic health record and care management systems to make or receive referrals, including a description of any technical barriers to making or receiving referrals and any differences in how you receive referrals from or make referrals to other provider organizations as opposed to your provider organization; (c) how, if at all, you make cost and quality information available to physicians at the point of referral when referring patients to specialty, tertiary, sub-acute, rehab, or other types of care; and (d) whether your organization, in

referring patients for services, ascertains the status in the patient's insurance network of the provider to whom you are referring the patient, and informs the patient if that provider is not in the patient's insurance network.

A founding priciple of BIDCO is the expectation that providers refer to other providers and facilities affiliated with BIDCO when clinically appropriate and to the extent that it is allowable by the payer. To that end, BIDCO has agreements with several payers to waive prior authorizations for in-network referrals. For referrals outside of the network, a PCP must sign off on the referral, which some members can do through the EHR. It is important to note that there are more than 40 EHR clinical documentation systems within the BIDCO network, so providers who cannot use an EHR for referrals complete the process telephonically and through manual information exchange. For some plans, if a BIDCO provider makes a referral to a provider outside of a plan's network, the referral is sent to BIDCO's Medical Director to make a determination about whether or not it is clinically necessary to handle out of network. For Medicare, in fee for service contracts as well as in the Pioneer ACO program, beneficiaries have freedom of choice of provider. Therefore, BIDCO does not inhibit a fee-for-service Medicare or Pioneer ACO patient's ability to choose his or her provider. BIDCO cites this as another example of the complexities and challenges of being able to provide seamless care for patients.

BIDCO does not share cost and quality information with providers at the point of referral at this time. However, BIDCO regularly shares information with physicians on cost differentials among providers as well as variance on costs of care or treatment for specific episodes of care. In general, BIDCO-affiliated provider offices check the network status of providers when processing referrals for patients. If an out of network provider is discovered, the referring provider notifies the patient.

BIDCO continues to seek ways to retain a patient's care within the BIDCO network, when appropriate, to maximize BIDCO's systems of quality and clinical integration. Unfortunately, the current tools that payers use to support these efforts are not effective. BIDCO encourages collaboration between health plans and employers to align patient incentives with BIDCO's – particularly in light of the growth of PPO enrollment. In particular, when community hospitals join BIDCO, they establish new clinical affiliations with BIDMC as an academic medical center, which gives BIDCO the opportunity to help community hospitals examine local service line support needs. For example, BIDH-Plymouth (formerly Jordan Hospital) now has enhanced thoracic surgery capabilities as a result of its partnership with BIDMC. The enhanced service line support ensures that BIDCO can coordinate care while keep patients close to their home for most services, and if clinically appropriate, visit BIDMC after exhausting services available in the patient's community.

Exhibit 1 AGO Questions to Providers

NOTES:

1. Data entered in worksheets is **hypothetical** and solely for illustrative purposes, provided as a guide to completing this spreadsheet. Respondent may provide explanatory notes and additional information at its discretion.
2. Please include POS payments under HMO.
3. Please include Indemnity payments under PPO.
4. **P4P Contracts** are pay for performance arrangements with a public or commercial payer that reimburse providers for achieving certain quality or efficiency benchmarks. For purposes of this excel, P4P Contracts do not include Risk Contracts.
5. **Risk Contracts** are contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to you, including contracts that subject you to very limited or minimal "downside" risk.
6. **FFS Arrangements** are those where a payer pays a provider for each service rendered, based on an agreed upon price for each service. For purposes of this excel, FFS Arrangements do not include payments under P4P Contracts or Risk Contracts.
7. **Other Revenue** is revenue under P4P Contracts, Risk Contracts, or FFS Arrangements other than those categories already identified, such as management fees and supplemental fees (and other non-claims based, non-incentive, non-surplus/deficit, non-quality bonus revenue).
8. **Claims-Based Revenue** is the total revenue that a provider received from a public or commercial payer under a P4P Contract or a Risk Contract for each service rendered, based on an agreed upon price for each service before any retraction for risk settlement is made.
9. **Incentive-Based Revenue** is the total revenue a provider received under a P4P Contract that is related to quality or efficiency targets or benchmarks established by a public or commercial payer.
10. **Budget Surplus/(Deficit) Revenue** is the total revenue a provider received or was retracted upon settlement of the efficiency-related budgets or benchmarks established in a Risk Contract.
11. **Quality Incentive Revenue** is the total revenue that a provider received from a public or commercial payer under a Risk Contract for quality-related targets or benchmarks established by a public or commercial payer.

2013

	Risk Contracts		**FFS Arrangements**		**Other Revenue**		
	Total Claims-Based Revenue, Budget Surplus/(Deficit) Revenue & Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	78,063,821	N/A	N/A	N/A	N/A	N/A	N/A
Tufts Health Plan	23,071,419	N/A	N/A	N/A	N/A	N/A	N/A
Harvard Pilgrim Health Care	32,993,754	N/A	N/A	N/A	N/A	N/A	N/A
Fallon Community Health Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CIGNA	N/A	N/A	N/A	N/A	N/A	N/A	N/A
United Healthcare	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other Commercial	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Commercial	134,128,994	N/A	N/A	N/A	N/A	N/A	N/A
Network Health	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Neighborhood Health Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A
BMC HealthNet, Inc.	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Health New England	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Fallon Community Health Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other Managed Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Managed Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A
MassHealth							
Tufts Medicare Preferred	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Blue Cross Senior Options	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other Comm Medicare	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Commercial Medicare Subtotal	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicare	127,949,427						
Other							
GRAND TOTAL	262,078,421						

2014

	Risk Contracts		**FFS Arrangements**		**Other Revenue**		
	Total Claims-Based Revenue, Budget Surplus/(Deficit) Revenue & Quality Incentive Revenue						
	HMO	PPO	HMO	PPO	HMO	PPO	Both
Blue Cross Blue Shield	90,740,775	N/A	N/A	N/A	N/A	N/A	N/A
Tufts Health Plan	29,946,502	N/A	N/A	N/A	N/A	N/A	N/A
Harvard Pilgrim Health Care	34,368,930	N/A	N/A	N/A	N/A	N/A	N/A
Fallon Community Health Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A
CIGNA	N/A	N/A	N/A	N/A	N/A	N/A	N/A
United Healthcare	3,782,844	N/A	N/A	N/A	N/A	N/A	N/A
Aetna	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other Commercial	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Commercial	158,839,051	N/A	N/A	N/A	N/A	N/A	N/A
Network Health	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Neighborhood Health Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A
BMC HealthNet, Inc.	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Health New England	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Fallon Community Health Plan	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other Managed Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Managed Medicaid	N/A	N/A	N/A	N/A	N/A	N/A	N/A
MassHealth							
Tufts Medicare Preferred	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Blue Cross Senior Options	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Other Comm Medicare	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Commercial Medicare Subtotal	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Medicare	162,035,672						
Other							
GRAND TOTAL	320,874,723						